LEA Medicaid Billing - Service Documentation - Health Paraprofessional Birthdate: _____ ICD 9 code(s) Building: ____ Student name: _____ ICD 9 code(s): _____ (primary) School district: **Services:** Procedure code Date of Time in Total time Service Comments / Student response Medical supplies - Initials Time out Service (minutes) code (see codes below) type & quantity (see table)

Total time _____ (minutes) (Procedure code T1019 – school time) Total cost - Medical supplies _____ ___

Total time _____ (minutes) (Procedure code T2001-U9 – transportation) (Procedure code T5999 - \$25 max/month)

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Nursing specific services:		Non-Nursing specific services:		
Blood sugar check = BS	Metered-dose inhaler = MDI	Assist with ambulation = AA	Oral feeding = OF	Position/ transfer to side lyer = PSL
Catheterization = CA	Nebulizer treatment = NT	Assist in wheelchair = AW	Oral stimulation exercises = OSE	Range of motion exercises = ROM
Chest percussion = CP	Oral suction = OS	Assist on/ off bus = AB	Personal hygiene = PH	Toileting = T
Gastrostomy tube feeding = TF	Oxygen therapy = O2	Diaper/ brief change = DC	Position/ transfer to chair = PC	Other Health Monitoring = OHM
Medication admin. = MA	Seizure monitoring = SM	Lunch setup = LSU	Position/ transfer to stander = PS	Assist during bus $=$ ES

Service providers:

Signature	Initials	Position	Signature*		Initials	Posit	ion: Health prof. (below)
Signature	Initials	Position	Circle one:	School Nurse	PT	OT	SLP

^{*} I attest that the services/ interventions provided by the LEA staff members are consistent with this student's treatment plan or specific goal(s) as described in the student's IEP. This does not imply my supervision of the LEA staff members, nor have I necessarily observed these services.

(12-31-07)